GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITY SERVICES

Developmental Disabilities Administration
Intake and Eligibility Unit

INTAKE APPLICATION

(Should you have questions or need help completing this form, please call the Intake Office at 202-730-1745)

The District of Columbia does not discriminate on the basis of race, color, religion, national origin, sex, age, marital status, personal appearance, sexual orientation, familial status, family responsibilities, matriculation, political affiliation, disability, source of income, or place of residence or business. Sexual harassment is a form of sex discrimination which is also prohibited by the Act. Discrimination in violation of the Act will not be tolerated. Violators will be subject to disciplinary action.

Part I: Applicant Identifying Information:

Name:_____
(Last Name) (First Name) (Middle Name)

Address: _____
Number and Street Apt.# City State Zip Code

Telephone Number:_____ Ward:_____

DOB: _____ Place of Birth: _____

Social Security #: _____ Sex: [ ] Female [ ] Male

Part II. Medical Insurance Information:

	Yes	No	Number:
None:	[ ]	[ ]	
Medicaid:	[ ]	[ ]	
Medicare:	[ ]	[ ]	
Private Insurance:	[ ]	[ ]	

If you answered "yes" for private insurance, please provide name of insurance, group & ID #:

Part III. Family Information, nearest relative, Guardian:

Parent's/Guardian's Name: _____
(Last Name) (First Name) (MI) Relationship

Address: _____
(Number and Street) Apt. # City/State Zip Code

Telephone Number: _____

Part IV. Referral Source:

Contact Person: _____ Telephone No.: _____
Agency: _____
Address: _____

Part V. Emergency Contact Information: _____

Name/Relationship: _____
Address: _____
(Number and Street) Apt.# City/State Zip Code
Telephone Number: _____

Part VI. Financial Statement of Application and/or Family:

Income and Benefits Resources (List income and benefits) Check each line yes or no. If yes, enter the amount in the last column. If not received monthly, indicate how often.)

Source of Income	Yes	No	Amount	How Often Received
Work Income (wages)	[ ]	[ ]	$	
Self Employment Income	[ ]	[ ]	$	
Public Assistance	[ ]	[ ]	$	
SSI	[ ]	[ ]	$	
SSA/VA/Railroad	[ ]	[ ]	$	
Payments from Trust Fund	[ ]	[ ]	$	
Other Income/ Specify	[ ]	[ ]	$	
Total Monthly Income:			$	

Property owned (List all property in which you have ownership/interest).

	Yes	No
None	[ ]	[ ]
Farm land or city lots	[ ]	[ ]
Buildings or property	[ ]	[ ]
Subsidized Housing	[ ]	[ ]

Number of family members:_____

Who is payee for the applicant's income and/or benefits?_____

Part VII. Educational/Training/Employment (Begin with the most recent):

Agency Name: _____ Dates: _____
Address: _____ Phone #: _____

Agency Name: _____ Dates: _____
Address: _____ Phone #:_____

Agency Name:_____ Dates: _____
Address:_____ Phone #: _____

Referral Source: _____ Phone: _____
Agency/Relationship:_____
Address: _____

Part VIII. Has applicant been diagnosed with any of the following developmental disabilities? Please check all that apply.

[ ] Mental Retardation
[ ] Cerebral Palsy
[ ] Epilepsy
[ ] Seizure Disorder
[ ] Pervasive Developmental Disorder (PDD)
[ ] Downs Syndrome
[ ] Autism
[ ] Other

At what age was the applicant's condition diagnosed? _____
By whom was the condition diagnosed (Psychologist/Physician Medical Facility)?
_____

Part IX. <u>Requested Services</u>:

Yes	No	
[ ]	[ ]	Home and Community Based Service Waiver
[ ]	[ ]	Residential
[ ]	[ ]	Day Program
[ ]	[ ]	Transportation
[ ]	[ ]	Case Management
[ ]	[ ]	Other/Specify

Part X. Required Documents (The more complete the documentation, the more expeditiously the application can be processed.

[ ] Birth Certificate
[ ] Social Security Card
[ ] Proof of District of Columbia Residency
[ ] All Psychological evaluations, one prior to 18th birthday and one current within six months

The statements above are accurate to the best of my ability. I declare them to be true. Any significant changes in these circumstances will be immediately made known.

_____
Signature of Applicant Date

_____
Signature of Relative/Guardian Date

<u>For Official Use Only</u>:

Date Application Received: _____
Assigned Intake Case Manager: _____

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT ON DISABILITIES SERVICES

Department on Disabilities Services

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby provide authorization for

_____ to release to the Department on Disabilities Services (DDS), or any employee of that agency, the following information:

The purpose of the release of information is to assist DDS in determining my eligibility for services and in providing appropriate services to me.

I understand that this release applies only to information existing prior to the date of the signing of this release. I further understand that I may revoke this authorization at any time in the future.

_____ _____
Signature Date

Parent/Guardian: (Signature of Parent/Guardian is needed only if individual is not yet 18 years old or is not otherwise competent to provide informed consent.)

_____ _____
Signature Date

_____
Printed name of Parent/Guardian

Witnessed:

_____ _____
Signature of Witness Date

_____
Printed name of Witness